

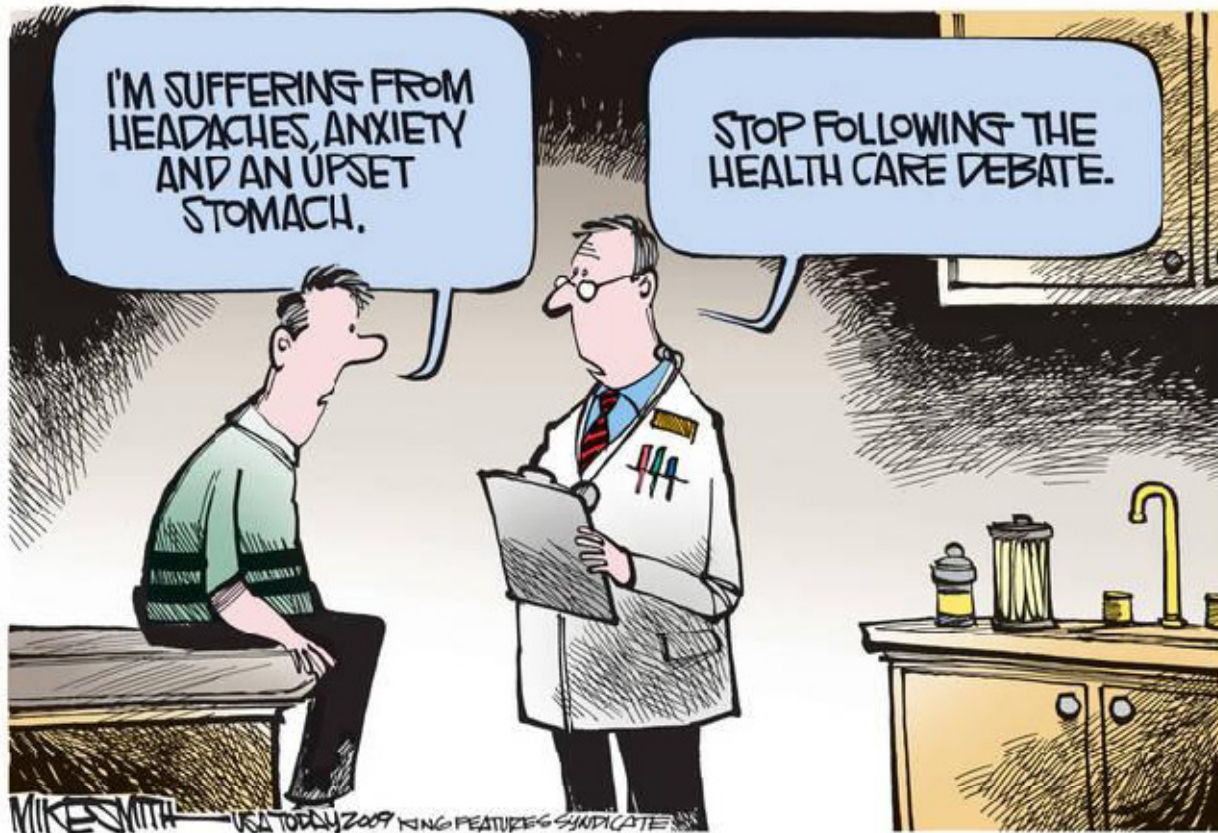


Health Care Reform

Impact on People with Disabilities

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Where is Delaware Now?

March 2010:

- 175,979 Delawareans enrolled in Medicaid
 - 6,444 children enrolled in the Delaware Healthy Children Program (CHIP)
- 



Uninsured

- Over the past few years uninsured in DE has risen from 9.9% to 11.2%
- Approximately 101,000 are without insurance at any given time- (this is a 2008 estimate)
- Approximately 28% or 28,000 are eligible for public benefit through Medicaid (21,000 or CHIP 7,000)
- Another 20% are eligible for CHAP – Community Health Access Program



Who Are the Uninsured

- 23% - under the age of 19
- 54% - male
- 69% - white
- 59% - own or are buying their home
- 21%- live alone
- 80% - are above the poverty line
- 34%- with household income over %50,000
- 59% - are working adults
- 9% - are self-employed
- 21% - are non citizens




Uncompensated Care

- Cost Shift – providers attempt to recover unpaid or underpaid costs of care delivered to one patient by increasing costs and passing it on to another patient population
- 1999 – 28% cost shift in DE Hospitals due to uncompensated care to the uninsured- For every \$100 of hospital costs, the total commercial insurance market paid an extra \$28
- Health Care Costs - \$6.5 billion was spent on personal health care (\$7,485 per person) in DE in 2008 – highest point in 10 years- Average rate of increase is 5% per year

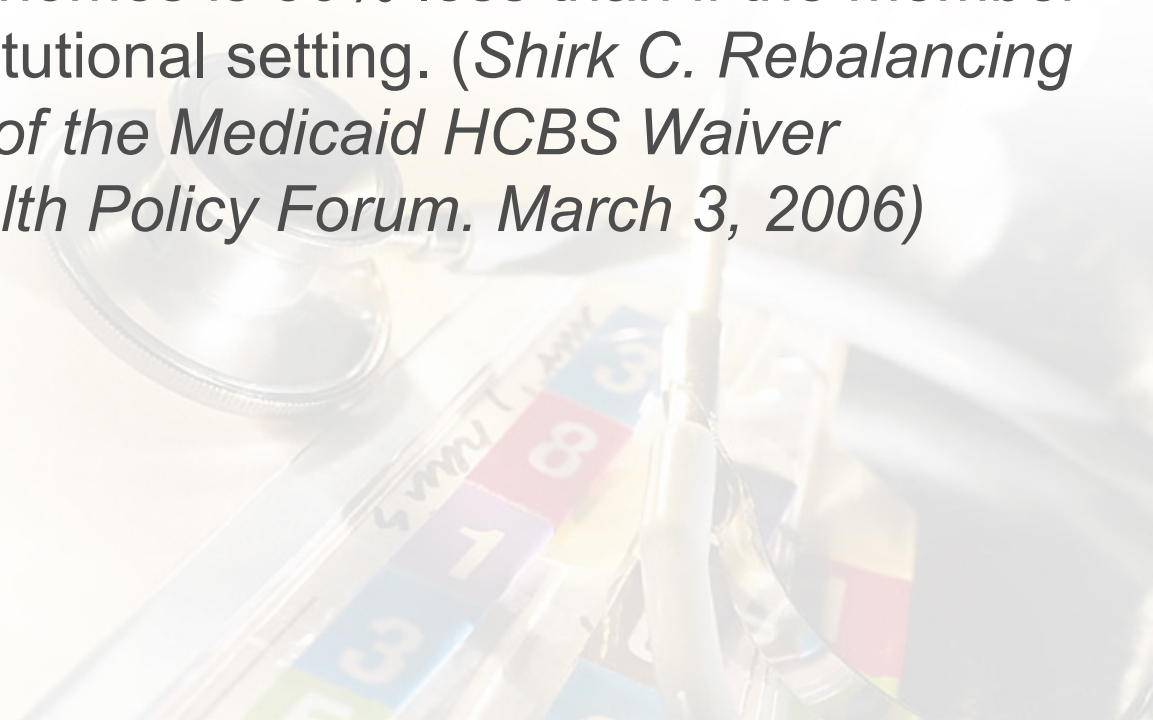


Community Healthcare Access Program

- Focus – to connect to primary care medical homes as well as specialty services, linkage to Screening for Life, Medicaid and VA
 - Patients with incomes below 200% of FPL (\$44,000 for family of 4)
 - Matched with medical service provided through community hospitals, community health centers and a network of 521 private physicians who participate on a voluntary basis
 - Over 22,000 low-income uninsured individuals have been served by CHAP
 - Outcomes
 - Fewer hospital emergency room visits
 - Shorter hospital stays
 - Improved rates of preventative health screenings
 - Improved control of chronic disease
- 



Long Term Care Conversion

- Studies continue to show cost-effectiveness of keeping long term care beneficiaries in a home or community setting. Nationwide, the cost of providing health care services to members in their own homes is 50% less than if the member were placed in an institutional setting. (*Shirk C. Rebalancing Long Term. The Role of the Medicaid HCBS Waiver Program National Health Policy Forum. March 3, 2006*)
- 



Opportunities

- Rebalance long term care system to a community based system
- Potential savings as more Medicaid beneficiaries are diverted from costly hospital and facility based care (*On average, Medicaid dollars can support nearly 3 older individuals and adults with physical disabilities in HCBS for every person in a nursing home – AARP Public Policy Institute 2008*)
- Managed care typically requires less cost sharing
- Single entity can facilitate care coordination which has led to quality
- Risk based managed care payments provide incentives to manage services and costs
- Potential to integrate and coordinate care across the long-term care continuum if the MMLTC model includes both Medicaid and Medicare (PACE)



Public Law 111-148 – Historic Legislation



- Patient Protection and Affordable Health Care Act (H.R. 3590) into law on March 23, 2010
- Health Care & Education Affordability Reconciliation Act (H.R. 4782) was signed on March 25, 2010
 - Included negotiated differences between the House and Senate bills and revised the student loan program

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Purpose

- Expand Coverage and access to care
 - 32 million uninsured will be covered
 - New Insurance Exchange with Premium Sharing Subsidies, and Cost Sharing Caps
 - Large Expansion of Medicaid Eligibility
- Significant Insurance Market Reforms
- Emphasis on Prevention
- Bending the Cost Curve over time



Insurance Market Reforms





Insurance Market Reforms

- Bars pre-existing condition exclusions for everyone (2014)
 - Bars pre-existing condition exclusions for children under 19 (6 months after enactment)
 - No coverage exclusions for specific conditions
 - No higher premiums or fees for such conditions
- Prohibits coverage rescissions (6 months)
 - Insurers drop individual when s/he gets sick or apparent pre-existing condition is discovered
- Prohibits annual limits (2014)
 - Prior to 2014: “Restricted” annual limits, to be defined by HHS Secretary are permitted
- Prohibits lifetime limits on coverage (6 months/September 23)



Insurance Market Reforms

- Bans discrimination based on health Status, medical condition (mental or physical illness), disability (2014)
- Guaranteed issue and renewability
 - Small group and Individual plans must accept every employer and individual who applies





Expanding Coverage

- Coverage for Dependents (IRS Definition) (6 months):
 - Must provide coverage to a beneficiary's dependent child until the child turns 26
 - Child does not have to live at home
 - HHS Secretary will issue regulation
- Temporary High Risk Pool (90 days to 2014)
 - Citizens with pre-existing conditions who were uninsured 6 months prior to applying for coverage in the pool
 - Pool operated by HHS or states
 - \$5 billion provided
 - States making decision right now
- Health Benefits Advisory Committee led by Surgeon General will recommend essential benefits package (established in 60 days)



Coverage: Small Business Tax Credits (2010)

- Eligibility: Employers with fewer than 25 full time employees (or a firm with fewer than 50 half time workers) who
 - pay average annual wages of less than \$50,000
 - who provide health insurance to their employees
- Worth up to 35% of employer's premium costs in 2010. January 1, 2014 worth up to 50%
- Gradual phase-out for firms with average wages between \$25,000 - \$50,000 and those with between 10 and 25 employees
- **Non-Profits eligible for payroll tax deduction if they fit above criteria –worth up to 25% of employer's premium costs**



Expand Coverage

- **Expands Medicaid eligibility to 133 % of Federal Poverty Level (2014) -**
 - approximately \$14,600/ individual; \$29,400/family of 4
 - Includes childless adults
 - Provides national base of seamless coverage – no asset or resource test
- **Federal Share (FMAP):**
 - 100% for newly eligible first 3 years (2014 – 2016)
 - Phases down to 90% for 2020 and subsequent years
- Provides full funding for **CHIP** through 2015 and continues authority through 2019. Children on CHIP would be transitioned to Medicaid or into Exchange.



Delaware Focus

- Medicaid Expansion

States are required to extend Medicaid eligibility to everyone younger than 65 with incomes up to 133% of FPL (\$29,327 family of 4).

2014 – 2016 - Federal government pays 100%

2017 – Delaware will pick up 5% of cost

2020 - 90% of cost

Delaware provides expanded coverage to 27,000 Delawareans up to 100% FPL - Federal government picks up 53% of the cost

2014 – the federal match will increase to 75% and by 2020 up to 90% of cost



Health Insurance Exchanges (2014)

- Creates state-based “Health Insurance Exchanges”, or marketplace to increase choice, provide competition
- Private insurance plans that meet minimum standards on benefits and cost-sharing set forth in regulations
- Small Business Health Options Program Exchange – Non-profits eligible
- Multi-state Exchanges run by HHS for states that choose not to operate their own Exchange
- Small Employer/Non-Profit: 100 employees or less the state defines as 50 or less
- Large Employers: Can participate in Exchange, at each state's discretion (2017)



Essential Benefits Package for Exchange Plans

- Hospitalization, emergency services, ambulatory (i.e. outpatient) services
- Prescription drugs and laboratory services
- Rehabilitative and habilitative services and devices
 - pre-health care reform insurance policies did not cover them or severely limited the number of treatments!
 - Devices includes “DME”
- Mental health and substance use disorder services including *behavioral health* treatment
- Preventative and wellness services and chronic disease management
- Pediatric services including dental and vision care
- Maternity and newborn care



Defining Exchange's Essential Benefits

- HHS Secy. must ensure that scope of benefits are equal to scope of benefits provided by typical employer sponsored plan
- Establish that benefits are not denied based on:
 - Individual's "present or predicted disability, degree of medical dependency, quality of life, age or expected length of life"
- Dept. of Labor to conduct survey of employer sponsored plans, provide report to inform HHS Secy's determination
- Will be a chance for public comment



Making Coverage Affordable

- Tax credits provided for individuals/families between 133% - 400% Federal Poverty to buy coverage in Exchange (2014)
 - approximately \$11,000/individual; \$88,000 family of four
- Paid by government directly to insurer
- Limits on cost sharing: deductibles, coinsurance, copayments
 - 100-200% FPL: \$1,983/individual; \$3,967/family
 - 200-300% FPL: \$2,975/individual; \$5,950/family
 - 300-400% FPL: \$3,987/individual; \$7,973/family
- Small group market plans are prohibited from deductibles greater than \$2,000 for individuals and \$4,000 for families



Individual Responsibility (2014)

- Those who are uninsured add over one thousand dollars to the average premium of families with insurance.
- Everyone will be asked to share responsibility for lowering costs and covering more people
- Tax penalties for no coverage - IRS:
 - 2014: \$95
 - 2015: \$325
 - 2016: \$695 OR
- Percent of household income: 1% in 2014, 2% in 2015, 2.5% - 2016 and after
- Exempts individuals with incomes too low to pay taxes (\$9,350) or if premiums exceed 8% of income



Employer Responsibility (2014)

- Employers with 50 or more full time employees (FTEs) who does NOT offer coverage
 - for every full-time employee that receives a premium credit for the Exchange must pay penalty
 - FTE= 30 or more hours per week
 - Part-time employees: Less than 30 hours per week



Prevention and Wellness





Prevention and Wellness

- Establishes a National Prevention, Health Promotion and Public Health Council and policy advisory group chaired by S.G.
- Prevention and public Health Fund established for *transformational sustained* investments - \$750 million in FY 2011
- Authorizes numerous prevention and wellness programs such as:
 - Community Transformation Grants
 - Comprehensive workplace wellness programs
 - Education and Outreach Campaign
 - Oral health prevention
 - Wellness program for Medicare beneficiaries
 - Individualized wellness plans for at-risk individuals



Medicaid/Chronic Disease Prevention

- 5 Year Grants to states (2011 or when Sec. develops program) for incentives for beneficiaries for:
 - Tobacco cessation, weight reduction and control, cholesterol reduction, blood pressure reduction, diabetes onset reduction or improved management of diabetes
 - States can provide sub-grants/contracts to Medicaid providers, community based or faith-based organizations



Community Transformation Grants

- Purpose: Implement, evaluate and disseminate evidenced-based community programs to:
 - prevent the development of secondary disabilities
 - reduce chronic disease rates
 - address health disparities
- Plan Activities Must Focus on 7 areas including individuals with disabilities
- Eligible entities:
 - state or local government agencies, national network of community based organizations; state or local non-profit organization
- Authorization: Such sums – 2010 – 2014
- Acting through Director of CDC

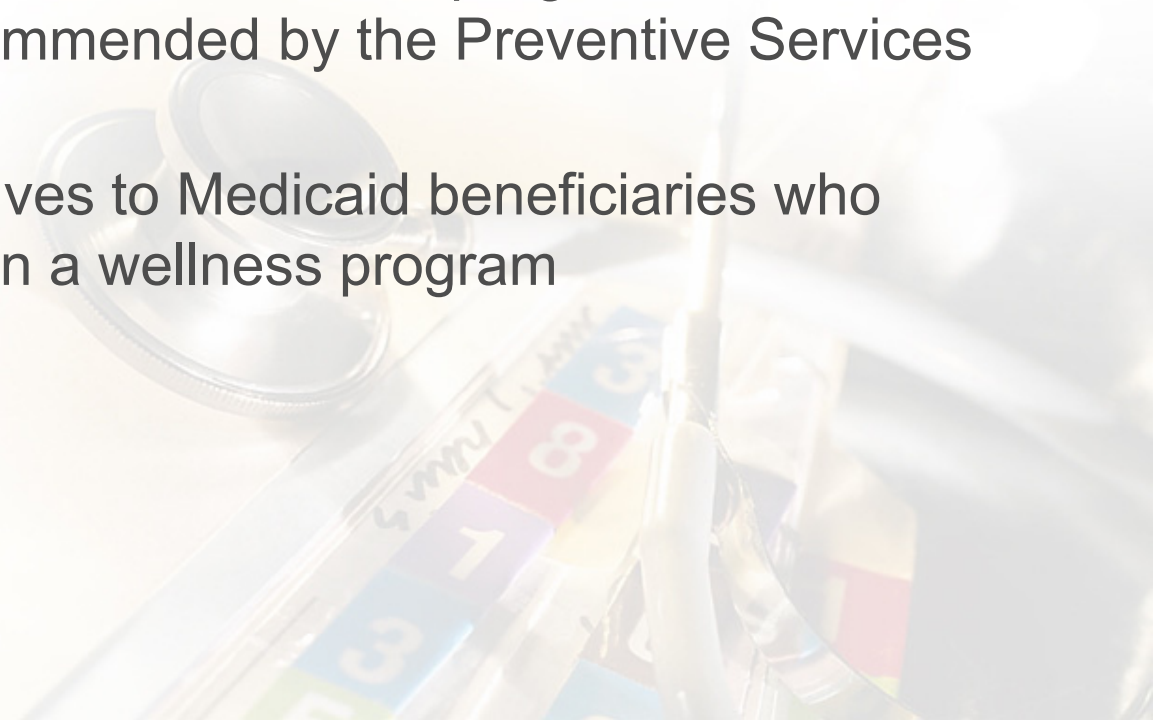


Increasing and Improving the Workforce

- Increases Medicaid reimbursement for primary care physicians and pediatricians to Medicare rates (2013 and 2014)
- Primary Care Training Grants for Medical Schools
 - training on treating individuals with disabilities is one of priority populations
- Oral Health: Grants for dental and dental hygiene schools, residency programs, public health programs
- Applicants must intend to establish a special populations oral health education or training program to teach oral health care for:
 - People with developmental disabilities and cognitive impairments
 - Complex medical problems, significant physical limitations
 - Vulnerable elders




Medicaid and Medicare Wellness

- Annual wellness visits and personalized prevention plans for Medicare beneficiaries (Jan. 2011)
 - No co-pays or deductibles for preventive services for Medicare patients (2011)
 - 1% FMAP increase for States if Medicaid program covers clinical preventive services recommended by the Preventive Services Task Force (2013)
 - Grants to provide incentives to Medicaid beneficiaries who successfully participate in a wellness program
- 



Community Health Centers

- \$11 billion increase FY 2011 for Community Health Centers
 - Pilot program to test the impact of providing at-risk populations who utilize community health centers an individualized wellness plan – such sums
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Accessibility

- Rehab Act amended to require accessible medical diagnostic equipment (within two years)
- Includes examination tables, examination chairs including chairs used for eye examinations or procedures, and dental examinations or procedures, weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals



Data Collection and Health Disparities

- Requires the federal government to collect health survey data from people with disabilities to enable better understanding of the health of people with disabilities compared to other minority groups.
- HHS must survey health providers to assess access to care and treatment for people with disabilities to identify:
 - locations where people with disabilities access acute (including intensive), primary, and long-term care
 - the number of providers with accessible facilities and equipment
 - the number of providers' employees trained in disability awareness and patient care
- Requires development of recommendations for quality measures to improve the quality of health care for individuals with disabilities



Long Term Services and Supports



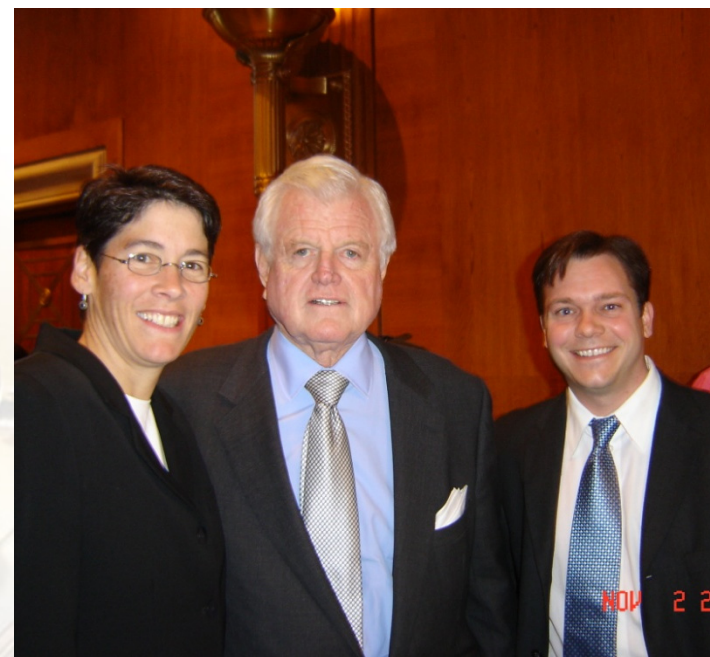


Long Term Services

- Disability and aging communities worked together
- **Goal – Ensure two-pronged inclusion of LTSS in health reform:**
 - National LTSS insurance program – avoid impoverishment
 - Improve Medicaid – eliminate institutional bias

Community Living Assistance Services and Supports (CLASS) Act, Title VIII, P.L. 111-148

- New national LTSS insurance program
- Based on voluntary payment of premiums
 - Pay premiums through employer (when willing)
 - Automatic enrollment with opt-out
 - Pay premiums directly, if employer chooses not to participate
 - Nominal premium (\$5.00) for full-time students and people with income below poverty level
- Vesting after 5 years of premium payments



- Eligibility to participate/enroll
 - Must be working to enroll
 - cannot enroll family members unless they are employed
 - No exclusions based on pre-existing conditions
- Benefits eligibility is based on functional need
 - Need for assistance with activities of daily living or equivalent

- Cash benefits for maximum consumer and family control
 - At least two tiers of payment levels – minimum \$50/day (\$18,000/year)
 - No impact on federal benefits eligibility
- No means-testing
 - No need for lifetime impoverishment
 - Individual can continue to work
- Advocacy and advice/assistance available

- Secretary of HHS to develop the program
 - Consults with CLASS Independence Advisory Council, including people with disabilities
 - Personal Care Attendants Workforce Advisory Panel (in 90 days)
- Separate CLASS Independence Trust Fund
- Program can pay for itself AND take the LTSS pressure off the Medicaid program
- Effective date: January 1, 2011

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CLASS Act

- Department of Health and Human Services has responsibility to develop programs
- Design and Regulations
 - Enrollment process for workers
 - Process for paying premiums
 - Eligibility for cash benefits
 - Benefit payment procedures
 - Public education and enrollment

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Improving LTSS in Medicaid

The need for change:

- Institutional Bias within Medicaid
 - Nursing homes mandatory
 - Community-based services optional
- People with disabilities and their families do not have an equal choice
- Long waiting lists for community-based services and supports



Community First Choice (CFC) Option, Section 2401, P.L. 111-148

- New state Medicaid plan option
- Comprehensive home and community based services for people eligible for an institutional level of care (nursing home, intermediate care facility (ICF), or IMD)
- States receive 6 percent additional federal Medicaid match for CFC services





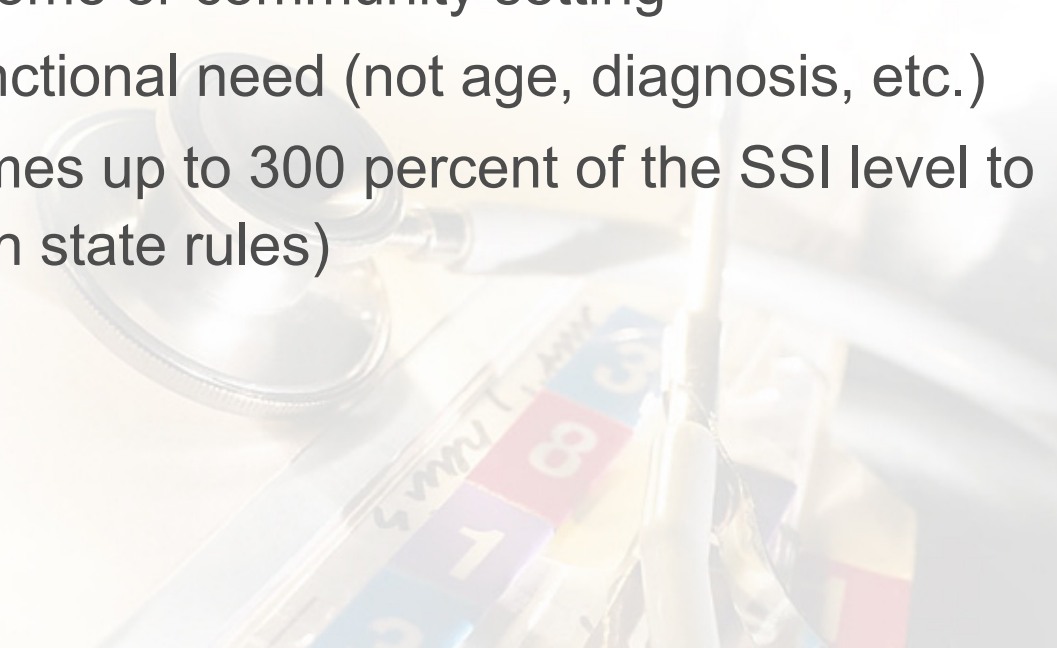
CFC Option

- Included services and supports:
 - Assistance with activities of daily living (ADLs)
 - Assistance with instrumental activities of daily living
 - Assistance with health-related tasks
 - Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish the above
 - Back-up systems or mechanisms (such as beepers, electronic devices)
 - Voluntary training on how to select, manage, and dismiss attendants

- Manner of service provision:
 - *Hands-on assistance*
 - *Supervision*
 - *Cueing*
- Other permissible services
 - transitions costs (rent and utility deposits, bedding, kitchen supplies, etc.)
 - needs identified in person-centered plan that would increase independence or substitute for human assistance (if the human assistance would have been paid for)



CFC Option

- Excluded services – room and board, assistive technology devices and services (except emergency back-up systems), medical supplies and equipment, home modifications, services covered under special education or vocational rehabilitation
 - Services provided in a home or community setting
 - Eligibility is based on functional need (not age, diagnosis, etc.)
 - Allows people with incomes up to 300 percent of the SSI level to be eligible (depending on state rules)
- 



CFC Option

- States must provide consumer-controlled services, statewide, in the most integrated setting appropriate
- States must create a Development and Implementation Council – majority of members must be people with disabilities, elderly individuals, and their representatives
- States must establish a comprehensive quality assurance system incorporating feedback from consumers, families, providers
- During the first year, states must maintain same level of expenditures as previous year
- Advocates could begin working with states now
- Available beginning October 1, 2011



Existing Home and Community Based Services (HCBS) State Plan Option (Section 1915(i))

- Existing Medicaid 1915(i) Option
 - States can provide services without a waiver
 - States must establish eligibility that is ***less strict than for institutional and HCBS waiver services*** – states serve people who are not eligible for the state’s HCBS waiver
 - Very few states have taken up this option to expand community-based services



Existing Home and Community Based Services (HCBS) State Plan Option (Section 1915(i))

- The need for change:
 - Allow states to cover people above 150 percent of poverty
 - Allow states to provide full range services allowed in *HCBS waiver* –including “other services approved by the Secretary”
 - Remove the authority for states to cap services, limit services to certain sections of the state, and maintain waiting lists



Section 2402, P.L. 111-148

New Law amends Section 1915(i) HCBS Medicaid Option:

- Income eligibility criteria aligned with other HCBS programs – allows people with incomes up to 300 percent of the SSI level to be eligible
- States may target certain populations in need for 5 years
- States may offer all services that are allowed under the HCBS waiver
- Repeals authority to cap the number of eligible people; to keep waiting lists; and to limit services to certain geographic areas

Effective Date: Appears to be April 1, 2010



New State Balancing Incentives Payments Program, Section 10202, P.L. 111-148


New law:

- Temporary increase in FMAP for states that make structural reforms to increase community services (over coverage of nursing homes or intermediate care facilities)
 - October 1, 2011 through September 30, 2015
 - Federal grants up to \$3 billion total for that period
 - States must apply for funds; meet certain criteria; and be selected by the Secretary of Health and Human Services




New State Balancing Incentives Payments Program, cont.

- Targeted to states that spend less than 50 percent of their LTSS funds on HCBS services
 - States spending less than 25 percent on LTSS will get a 5 percent increase in federal match
 - *Goal: bring total LTSS spending up to 25 percent*
 - States spending 26 to 50 percent on LTSS will get a 2 percent increase in federal match
 - *Goal: bring total LTSS spending up to 50 percent*



Some Additional Medicaid LTSS Provisions, P.L. 111-148

- Section 2403 - Extends Money Follows the Person Rebalancing Demonstration program through 2016
 - Also allows states to cover people institutionalized over 90 days
 - Section 2405 - Expands funding for Aging and Disability Resource Centers
 - \$10 million per year, FY 2010 through FY 2014
- 



Direct Support Workforce

- Significant emphasis on the health care workforce (doctors, nurses, paraprofessionals) and it includes the direct care workforce
- \$10 million is authorized for new training opportunities for direct care workers providing long term services and supports
- \$5 million is authorized for demonstration project to develop training and certification for personal and home care aids



Implementation

- Department of Health and Human Services
 - CLASS Act
 - Design/implementation of program/public education
 - Proposed and final regulations
- Centers for Medicare and Medicaid Services (CMS)
 - Community First Choice Option; Section 1915(i); State Rebalancing; Spousal impoverishment protections
 - Guidance to states
 - Funding decisions
 - Proposed and final regulations
- Will need your input and responses to alerts on regulations, etc.



Implementation, cont.


- Implementation of Medicaid LTTS changes
- States have many choices
 - Community First Choice Option
 - Section 1915(i) HCBS option
 - State Balancing Incentives
- Work with Governors, State Legislatures



State Preparation and Planning


Challenge for Delaware:

Maximize benefits for Delaware citizens to support the goals of widespread access to health insurance & health care, supporting people in community-based settings, and promoting healthy lifestyles.





State Preparation and Planning

- State leadership team – Led by DHSS
 - OMB – State Employee Benefit and Budget preparation
 - Department of Revenue – income exemption determinations
 - DMMA – Medicaid
 - DSS – process applications
 - DOI – oversight and certification of plans and regulate rate bands
 - DPH – prevention measures and services
 - DTI and DHIN – health information network
 - Health Care Commission
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Responsibilities

- Overseeing planning, development and implementation
- Identifying ways to build on existing infrastructures and programs, or to create a new entity within state government to house governance and oversight
- Ensuring appropriate coordination and collaboration across state agencies
- Engaging with relevant stakeholders to get buy-in and insights for reform implementation

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State Preparation and Planning

- Health Care Commission
 - Public Discussions
 - Coordination with Private Sector:
 - Doctors
 - Hospitals
 - Community Based Health Centers
 - Insurance Companies



Resources

- AUCD website – www.aucd.org
 - Select: public policy:
 - Then Health Care



Hill visits during the Disability Policy Seminar



Thank you.

Questions?

